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Disarming the Demon: Dealing with Denial in Alcoholism Intervention

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DISARMING THE DEMON: DEALING WITH DENIAL IN ALCOHOLISM INTERVENTION

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ABSTRACT

This thesis will utilize documentary research methods to identify the progressive nature of denial as it relates to alcoholism intervention. This thesis will discuss the progression of denial and the related treatment methods which may be effective in breaking through the denial. This thesis will identify denial as it operates as a defense mechanism to protect the alcoholic and his or her social system from the pain of the addiction. The role of family, friends, and employers will be examined to determine how society itself contributes to the progression of denial and, conversely, how society can assist in ceasing the progression of denial. The issue of codependency and the role of Alcoholics Anonymous and of Employee Assistance Programs will be discussed with respect to how they relate to the alcoholic's denial process. Denial will be discussed as it exists before, during, and after the completion of formal alcoholism intervention.

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CHAPTER 1

INTRODUCTION

Clifford & Soares (1990) report that it has been etimated that approximately 12 Million people in the United States suffer from alcohol dependence. Alcoholism is so pervasive in American society that countless Americans are affected by the negative impact of alcoholism on either a direct or indirect level. Bell & Bell (1989) report that as the number one drug abused in the United States, alcohol is the largest health care problem following heart disease and cancer. Countless research efforts have attempted to isolate the causes, consequences, and progression of alcoholism.

Wallace (1989) cites that research and clinical observations of the past several decades have made it increasingly clear that neither a simple behavioral model nor a simple disease concept can adequately explain alcoholism. Alcoholism is not merely a physical problem, but a psychological and sociocultural problem as well. Mind and body enter into the development and maintenance of the disease, as do society and culture. Alcoholism is a progressive disease that, left alone, will only become more severe and maladaptive to alcoholics, their

families, and society.

A primary focus in the study of alcoholism is the impact of denial upon the maintenance and progression of the disease. Clifford & Soares (1990) stress that denial is apparent at every stage of the alcoholic's "drinking career". Denial is a defense mechanism utilized to assist the alcoholic in coping with the pain of the addiction. Unfortunately, denial also functions to maintain the addiction by delaying treatment.

The Purpose of This Study

This thesis will utilize documentary research methods to identify the progressive nature of denial as it relates to alcoholism intervention. This thesis will discuss the progression of denial and the related treatment methods which may be effective in breaking through the denial. The role of family, friends, and employers will be examined to determine how society itself contributes to the denial process and how, conversely, society can assist in ceasing the progression of denial. This thesis will discuss denial as it operates as a defense mechanism to protect the alcoholic and his social system from the pain of the addiction. This thesis will address the progression of denial as it exists prior to treatment, throughout treatment, and after treatment has been concluded. This thesis will also discuss denial as it relates to the fellowship of Alcoholics Anonymous.

Limitations of This Study

With respect to time limitations, there was no predetermined limitation with respect to time parameters. A definite preference existed in selecting studies which were copyrighted within the last five years. However, to demonstrate the fundamental, timeless nature of denial, sources were randomly selected which were published prior to 1985. In addition, classic studies such as the studies written by Elisabeth Kubler-Ross or Anna Freud were accessed to assess the role of denial as a defense mechanism.

A literature search was processed from general literature in the areas of alcoholism and related psychological defense mechanisms, from appropriate journal articles, and from business and professional journals. Collegiate libraries, public libraries, and the Hazeldon Foundation were accessed to secure sources for this thesis. This study secured sources in an effort to provide an overview of the issue of denial with respect to its presentation in the literature. This study is by no means an exaustive study as a vast number of studies have been conducted in the area of alcoholism.

Although a few of the journal articles concentrated on the issue of denial, the bulk of the sources utilized in this study were not centered around the issue of denial as literature was not found which concentrated on denial in its entirety. Rather, denial is generally described as one of the assumptions of the research efforts which

proposed to investigate the successful implementation of alcoholism intervention. Such studies provide the bulk of the information describing alcoholic denial today. These studies were accessed to determine their perception and assessment of the denial process.

Assumptions of This Study

Throughout this thesis, it will be assumed that the reader has a basic understanding of the disease of alcoholism and alcoholism intervention. Due to its rather limited scope, this thesis will only discuss formal and informal alcoholism intervention approaches as they relate directly to denial. As such, this thesis will only discuss portions of the varied formal and informal treatment approaches. It will be further assumed that the reader has a basic concept of codependency, enabling, Alcoholics Anonymous, and employee assistance programs.

Definition of Terms

In this thesis, alcoholism will be referred to as a disease to remain consistent with current research findings in the alcoholism field. Alcoholism may also be referred to as either substance abuse or addiction despite the fact that these terms may also embody other addictive drugs. For the purpose of this study, the drug of addiction or abuse will be alcohol. In addition, a differentiation will not be made between alcohol abuse

and alcohol dependence. As alcoholism is progressive, the alcohol abuser generally becomes dependent upon the drug in a variable period of time. Denial impacts alcoholism in the early stage of the addiction so this stage of the disease is relevant to this thesis.

Organization of This Study

The organization of this thesis will consist of six chapters. This first chapter is an introduction which provides the reader with an overview of the thesis with respect to purpose and intent. The second chapter will discuss denial as denial operates as a defense mechanism to protect individuals from pain. The third, fourth, and fifth chapters will discuss denial as it exists before, during, and after formal alcoholism intervention. The last chapter will provide conclusions and recommendations for further research. Throughout this thesis, denial will be discussed as it exists among alcoholics, their families, and their employers or society in general. The six chapters in this thesis are entitled: Introduction, Denial: A Defense Mechanism, Pre-Treatment Denial, In-Treatment Denial, Post-Treatment Denial, and Conclusion and Recommendations.

CHAPTER 2

DENIAL: A DEFENSE MECHANISM

The Defense Mechanism

Almost everyone denies a given reality from time to time. In time - given a few minutes, hours, days, or weeks - an individual will generally drop their use of denial and acknowledge reality. Ufema (1990) states that an indiviual is often not aware that he or she is utilizing denial as a defense mechanism; he or she unconsciously utilizes denial to buffer some frightening or painful information. Vaillant (1977) defines denial as the literal denial of an external reality which effectively distorts and reshapes external reality to suit one's inner needs. Reality may become the individual's view of reality, not reality itself.

Weisman (1972) states that denial can be considered an adaptive defense mechanism as it only allows the person to confront reality when the person is emotionally ready to face this reality. Weisman further states that denial helps individuals to do away with a threatening portion of reality, but only because they may then participate more fully in contending with their problems at a later time. In the same vein, Kubler-Ross (1969) cites that

denial functions as a buffer after unexpected, shocking news allowing the person to collect himself and eventually mobilize other, less radical defenses.

Weisman (1972) describes denial as generally a temporary defense that is usually replaced by at least partial acceptance when the facts of reality are too blatant to ignore. In this view, denial is almost impossible to maintain over an extended period of time because inner perceptions will eventually force themselves upon even the most reluctant person. Essentially, Weisman defines denial as a temporary defense that can occur in almost any situation, act, or verbal expression in which one seeks to avoid reality or escape confrontation with something unpleasant and alarming.

Vaillant (1977) cites that the degree to which one utilizes denial to manage painful situations depends generally upon the severity of the situation and the overall emotional health of the individual. Accordingly, Kubler-Ross (1969) cites that if one's ability to defend oneself physically or emotionally becomes smaller and smaller, the psychological defenses have to increase manifoldly.

Maxwell (1986) stresses that using a psychological mechanism is not a conscious avoidance of problems, nor does it have to do with willpower, perseverance, or turning to others for help. Rather, Maxwell asserts that defenses are subtle, automatic, and largely unconscious psychological

processes that are reflected in our behavior and affect. Freud (1966) cites that the method of denial, upon which is based the fantasy of the reversal of the real facts into their opposite, is employed in situations in which it is impossible to escape from some painful external impression.

Maxwell (1986) discusses that defense mechanisms are utilized when an individual is unable to cope with a painful situation. If we can not cope, we must defend ourselves by unconsciously invoking a psychological defense mechanism. Rather than facing up to a conflict and making an attempt to overcome this conflict directly, we evade the threat to our self-esteem by evading the conflict. As such, one's sense of self-worth is preserved through self-deception.

Metzger (1988) cites that one may utilize defense mechanisms in a flexible or rigid manner, dependant upon how healthy an individual is emotionally as the use of defense mechanisms is mainly unconscious and related to the individual's level of psychological development. Vaillant (1977) asserts that defense mechanisms can be categorized into four general levels of individual functioning which include: the psychotic mechanisms, the immature mechanisms, the neurotic mechanisms, and the mature mechanisms. Vaillant claims that as an individual grows and develops emotionally, the individual will utilize higher levels of defense mechanisms to cope

with reality. Although healthy individuals may temporarily regress and utilize more primitive levels of defense mechanisms, such individuals will generally revert back to the use of higher level defense mechanisms.

Vaillant (1977) considers denial to be a psychotic mechanism which is generally displayed by children, psychotic adults, or perhaps healthy adults who periodically regress and deny temporarily to cope with a painful situation. Maxwell (1986) asserts that healthy toddlers and children occasionally employ the defense of denial to block out unpleasant events. As an adult, one may minimize and even temporarily deny facts from time to time. Yet, when faced with concrete evidence of reality, an individual will generally accept reality whether one likes it or not.

Maxwell (1986) states that in adults, a rigid, nonmodifiable, and repeated use of denial is a defense that is usually associated only with psychotic disorders and addiction. For an alcoholic, denial functions as more than a simple defense mechanism. In this view, the primary difference between the denial exhibited by an alcoholic from the denial exhibited by non-alcoholics is that alcoholic denial becomes pervasive and not a temporary way to deal with reality. In alcoholic denial, the denial will generally not subside until after the alcoholism has been confronted.

A Characteristic of Alcoholism.

Amodeo & Liftik (1990) define denial as being characteristic and symptomatic of alcoholism: a predictable set of behaviors and processes displayed by alcoholics when confronted with their relationship to alcohol. This definition further stipulates that denial includes a variety of ego defense mechanisms, such as rationalization, projection, and avoidance. The purpose of these mechanisms is to prevent the alcoholic from acknowledging the realities of drinking behavior. As a characteristic of alcoholism, the presence of denial presents a sound indication that the individual is suffering from alcoholism. Denial is thus a symptom which attests to the presence of alcoholism.

A Reaction to Alcoholism.

Mueller & Ketcham (1987) define the denial experienced by alcoholics as an inborn, automatic, protective system that shields one from the emotional trauma of being sick, debilitated, or somehow abnormal. In their view, denial is not considered a characteristic of alcoholism but rather viewed as a way of masking fear and handling stress by pretending that the disease is not there or at least not that serious. Barnes, Aronson, & Delbanco (1987) assert that as the alcoholic continues to drink and incurs repeated negative consequences related to the drinking, the individual faces a conflict between the need to continue

to drink and the knowledge of the adverse effects of the drinking. The psychologic solution is to deny that the drinking has any negative effects - to simply deny any problems associated with drinking. Maxwell (1986) cites that by utilizing denial, the drinker is able to continue to drink while maintaining some modicum of self-esteem. These sources view denial as a result of the alcoholic process: a reaction to the disease, not a characteristic of the disease.

A Protector of the Addiction.

Trachtenburg (1990) defines addiction as a disease of denial for reality is restructured to subjucate the demands of the world to the demands of the addiction. Without denial, Trachtenburg states that the alcoholic would have to admit that his or her drinking is problematic as the alcoholic would be unable to avoid the negative effects of his drinking. Accordingly, Gallant (1987) cites that the denial mechanism plays a major role in the development of alcoholism as minimizing the severity of the drinking problem becomes an essential part of the alcoholic orientation to the environment. Trachtenburg (1990) further states that denial is necessary for the maintenance of the addiction as the alcoholism could not exist without the protective defense of denial as denial is viewed as a major factor in the development of alcoholism.

Biological Components of Denial.

Barnes, Aronson, & Delbanco (1987) cite that although denial is primarily a psychological defense mechanism, there is a large organic component as the repeated use of alcohol impairs intellectual and emotional functioning. Confusion, memory loss, and deteriorating physical health are all variables that contribute to denial as it applies to alcoholism. Mueller & Ketcham (1987) cite that in trying to understand alcoholic denial, it is crucial to remember that there are two key aspects to denial. First, there is the psychological process of using denial to handle stress, mask fear, and protect against trauma. Second, there are the associated physical changes in the brain which is caused by long exposure to alcohol that destroys the alcoholic's ability to "see" the alcoholism. So, with the compulsive consumption of alcohol, an organic component becomes involved which supports the denial.

The Denial System.

Anderson (1981) describes denial as a combination of physical, emotional, and psychological variables: a system of variables working together. Anderson defines denial as a shorthand term for a wide repertoire of psychological defenses and manuveurs that alcoholic persons unwittingly set up to protect themselves from the

realization that they do in fact have a drinking problem. Denial is viewed as a system which operates unconsciously and involves a distortion in perception and an impairment in judgement. The alcoholic reportedly becomes deluded and incapable of accurate self-awareness. Anderson perceives the denial system as a process which involves varied defensive manuveurs working together to distort reality.

Anderson cites that when the denial begins to fail, the alcoholic may unconsciously engage in various behaviors to support the denial system. Anderson further assesses that there are seven common defensive manueveurs which are utilized by alcoholics. These seven manueveurs are: simple denial, minimizing, rationalizing, blaming, intellectualizing, diversion, and hostility. Alcoholics therefore are believed to utilize a system of defenses related to denial to support their denial when the denial begins to falter after being confronted by reality.

Denial's Progressive Nature.

Ludwig (1988) cites that denial can, at times, progress and reach psychotic proportions - expecially if denial becomes global and immune to reason. Anderson (1981) states that the more painful the reality, the more pervasive the denial becomes. So, as one's alcoholism progresses, the denial system will progress and become more entrenched. Mueller & Ketcham (1987) state that denial becomes a

common and expected stronghold of the addiction: the stronger the addiction, the stronger the denial. For, as the disease progresses, perception is distorted, memory is fogged, emotions are out of whack, and the entire system of rational thought and perception short circuits. Mueller & Ketcham therefore assert that reasoning with an alcoholic is simply not possible because of the denial factor.

Brissett (1988) stresses that however denial is defined or discussed in the literature, there seems to be reasonable agreement that there are three main areas that are the focus of progressive alcoholic denial. The three central areas of denial outlined by Brissett include: the amount and extent of the drinking behavior, the connection between the drinking and the related problems in one's life, and the degree to which one is in control of the drinking behavior.

Interpersonal Vs. Intrapersonal Denial

Kimball (1978) asserts that denial becomes an attitude that permeates society and becomes a way of life for the entire social system of the alcoholic. Accordingly, Metzger (1988) states that individual denial is embedded in cultural denial. For not only does the alcoholic deny the alcoholism, but so also does the alcoholic's family, friends, employers, and society itself collude to deny the fact of the alcoholism. Brissett (1988)

claims that in this respect, denial can be considered interpersonal in that varied members of the addict's social system participate in the denial process. If one is to break through the alcoholic's denial, one must also break through familial and societal denial which inadvertently supports the denial process.

However, Brissett asserts that denial is intrapersonal for while denial admittedly has social consequences the denial itself is described as residing within the psychological makeup of the individual alcoholic. Familial and societal denial may also be considered intrapersonal denial in that the denial is assumed by families and society in response to the uncomfortable interactions with the addict. Mandelson (1966) cites that the denial exhibited on a group level functions to protect the social system.

CHAPTER 3

PRE-TREATMENT DENIAL

The Alcoholic's Denial

Schaef (1987) defines an addiction as any process over which we are powerless. Weisberg & Hawes (1989) discuss how, as a disease, alcoholism is relentlessly progressive and the rate of the progression varies, often with long periods of slow decline and then sudden periods of much more rapid deterioration. As the disease of alcoholism progresses, the denial experienced by the alcoholic progresses. Metzger (1988) states that denial can progress on a continuum from normal to pathological. Pathological denial is evident when someone maintains a belief that others do not hold; the longer this delusion is maintained, the further from shared reality is the beholder.

Westermeyer (1937) cites that even if the individual begins to acknowledge the symptoms of the alcoholism, denial operates so stongly as to prevent full awareness. Ludwig (1988) reports that as a result of the denial process, it is no wonder that only cataclysmic, psychological events, physical shock waves, or volcanic emotional upheavals are necessary to shatter the alcoholic's

complacency and reshape the landscape of his habitual attitudes.

Weisberg & Hawes (1989) stress that the alcoholic's willingness to pursue treatment, no matter how hesitantly, is the first major step toward recovery as it seems that a bottom must be reached for recovery to begin. Vaillant (1983) cites that a final set of variables that affect prognosis are those psychosocial variables which support the alcoholic's denial of his or her own condition. When these psychosocial variables which supported the alcoholic's denial begin to fail, the denial will begin to fail, and the alcoholic will seek help.

Glaser (1985) states that one of the most provacative factors in moving the victim of alcoholism toward treatment is to place upon the individual the responsibility of recognizing his or her own illness, as with heart disease, cancer, or any other such condition, and of taking the necessary steps toward recovery. Amodeo & Liftik (1990) discuss how many alcoholics may wait to hit bottom before seeking help; denial may prevent the alcoholic from acknowledging that a bottom has been reached. As such, alcohol related problems often become established over a decade or longer before the alcoholic begins to accept that a problem exists.

Trachtenburg (1990) cites that it is only when the physical and emotional pain of using the addictive substance overwhelms even the defense of denial that it is possible

for the addicted individual to operate outside the constraints of the addiction. Cull & Hardy (1974) cite that denial of one's physical condition, feelings, and social circumstances are often prominent features in the alcoholic's efforts to defend his or her actions.

Weisberg & Hawes (1989) discuss how many alcoholics hit "bottom" long before serious disruptions in their health, careers, or interpersonal relationships are experienced. "High bottom" and "low bottom" drunks are terms that refer to two differing levels of alcoholic progression needed for denial to be pierced and recovery to begin. When alcoholics reach such desperation that denial begins to weaken, Weisbeg & Hawes assert that there is a chance they will accept formal help.

According to Metzger (1988), the strength of denial is not the same in all alcohol abusers. In this view, no alcohol abuser is identical in behavior patterns to other alcohol abusers. Although generalizations may be made, alcoholics reach their "bottom" in rather unique patterns. It is for this reason that early intervention is sometimes able to break through the denial process. Weisman (1972) asserts that denying is a process, not a static event, so degrees of denial are never constant. Someone who is a major denier at one moment and under certain circumstances may be a minor denier in another situation.

Brissett (1988) concludes that once the denial system

of the alcoholic is broken, the alcoholic is said to have the ability to recognize and understand the problem and be able to take constructive action to change his or her life.

Familial Denial

Maxwell (1986) stresses that the alcoholic's denial is particularly troublesome because the denial invades the autonomy of others by causing significant others to question their own judgment and sanity. As the alcoholic actually believes that something or someone else, not the drinking, is the problem, family members may be inclined to believe the alcoholic's perception of reality because the alcoholic so blatantly believes this perception of reality.

According to Schaef (1987), as alcoholics lose contact with themselves as a result of the addiction, alcoholics lose contact with other people and the world around them. So, if the family members don't agree with the dependent's concept of reality, the alcoholic generally will project blame onto others. Peele (1988) cites that drug induced denial may prevent the anger that the alcoholic experiences from losing control over alcohol from being focused on the drug or the use of the drug. Hence, anger is turned onto oneself or others as part of the denial process. The denial is strengthened because the anger expressed by alcoholics is directed at others, not themselves.

Schaef (1987) emphasizes that those who work with addicts know that the most caring thing to do is not to embrace the denial and to confront the disease: this is the only possibility the addict has to recover. Accordingly, Maxwell (1986) cites that the only way we can be truly protective of ourselves and helpful to the alcoholic is to learn about the defensive behavior so that we do not play the game. Maxwell asserts that it is imperative that the family member does not tolerate or enable the addict's denial.

Beattie (1989) discusses how the family members become affected by the illness of alcoholism as a result of interacting with the addict. Beattie defines a codependent as the person who has let someone elses's behavior affect him or her and is obsessed with controlling other people's behavior. Schaef (1986) cites that one of the major characteristics of codependence is denial. This codependent denial reportedly functions to protect the codependent from the pain yet is maladaptive in that denial helps to maintain the addiction.

Schaef (1986) discusses how an emerging focus in the chemical dependency field has been the treatment of codependents as it was accurately believed that alcoholics would have less of a chance of attaining or maintaining sobriety if they remain with untreated families which would enable them to drink by making excuses for the alcoholic. Once codependents are treated, they are

liable to recognize and alter their self-defeating behaviors which operate to enable the addiction.

Maxwell (1986) describes how the family member first rejects the addict's behavior, then tolerates the behavior. Maxwell asserts that the family member therefore enables the addict and thereby promotes the progression of the addiction. By promoting the progression of the addiction, the family member also promotes the progression of denial which continues to strengthen the addiction. Weisberg & Hawes (1989) define enabling as anything the codependent does to shield the active alcoholic from the consequences of the addictive disease, or to help the alcoholic continue practicing the addiction.

Block (1970) acknowledges that lecturing and scolding the addict are of no avail as this only leads to further denial. Block perceives understanding as a prime requirement if one is to gain the alcoholic's confidence and help him or her. Yet, Schaef (1987) stresses that an alcoholic system is contagious, and those who live within it become infected with the disease sooner or later.

Employer and Societal Denial

Metzger (1988) stresses that alcoholic denial infects the family with denial; the alcoholic's friends, coworkers, and employers become infected as well. As such, the denial factor that permeates the abuse of alcohol inevitably

extends into the workplace. Castelli (1990) cites that alcoholism remains the number one drug problem in America's homes, neighborhoods, and workplaces.

Clifford & Soares (1990) cite that it has been estimated that during the 1980s, alcoholism cost U.S. businesses approximately $24 Billion to $30 Billion annually in lost work time and reduced productivity. According to Pace & Smits (1989), alcoholism touches every organization, either directly or indirectly. Wrich (1988) reports that at least 25% of any given work force suffers from the adverse effects of substance abuse.

Yet, Bacon (1989) concludes that some employers still find it hard to accept the idea that alcoholism could thrive in their own businesses. Deming (1990) cites that companies that resist fighting drugs inside their workplaces are ignoring how much employee drug abuse costs them and the savings that other companies have made since establishing drug free workplace programs.

Miller (1990) reports that the thought processes of the addict become altered by the haze of the addiction. This "haze" under which addicts function can only disrupt their professional life as well as their personal life. Kenyon (1988) asserts that the person will begin to fail to meet commitments and begin to make mistakes on the job; tardiness and absenteeism will begin to rise.

According to Pace & Smits (1989), substances widely used in society - especially alcohol - eventually will

find their way into the workplace and must be dealt with by management and unions. Ackerman (1988) cites that changes in an employee's work performance, in physical condition, and in social interactions can all be indications that an abuse problem exists. Mandelson (1966) describes how social or group denial serves to protect the social organism from disruption as the denial functions on a group level to protect the social organization.

According to Bacon (1989), employers say it is often a single incident that helps them see, for the first time, how vulnerable their businesses are to the plague of substance abuse. Such an incident may be necessary to break through the employer's denial.

Education and Denial

Peele (1988) cites that the best way to combat addiction both for the individual and for society itself is to inculcate values that are incompatible with addiction and with alcohol or drug induced behavior. Perhaps the best way to inculcate such values against tolerating addiction is through education. Mandelson (1966) concludes that psychological and social factors contributing to extensive denial are most often demonstrated as negative attitudes and prejudice. Accordingly, Metzger (1988) reports that education is a potent means of disarming denial.

Amodeo & Liftik (1990) discuss how some features

which appear to be resistance to treatment dissipate as the client learns more about alcohol and alcoholism. Education is therefore perceived as important because it decreases misconceptions and the related stigma model of alcoholism. Weisman (1972) cites that denial, like its opposite, affirmation, is grounded in biological, social, and psychological processes. While Schaef (1987) asserts that the addictive system views denial as a normal way of being in the world. Metzger (1988) concludes that when one presents objective information about the nature of alcohol, its addicting potential, and its effect on the body, one averts the moral model while providing service.

CHAPTER 4

IN-TREATMENT DENIAL

Traditional Progression of Denial

Literature in the area of alcoholism treatment generally focuses upon the issue of denial and its hindering capabilities upon the successful treatment of alcoholism. Although there are variations in the denial experienced by individual alcoholics, the denial follows a general pattern as the addiction progresses from early to late stages. Amodeo & Liftik (1990) have compared the general progression of denial with the progression of alcoholism. The treatment professional should be aware of these patterns of denial so that he or she can more accurately assess the alcoholic denial and its potential affect on treatment.

While the client is in the early stages of the addiction, the client will generally insist that there is nothing problematic with the amount or patterns of alcohol consumption. Although the denial is in the early stages and more easily penetratable, the alcoholic's denial is convincing because few if any problems arise that can be traced conclusively to the alcohol consumption. The denial may be based on misinformation so didactic information about alcoholism is essential in dealing

with denial. Denial should subside as the alcoholic learns more about the facts of alcoholism. If the client doesn't receive the appropriate information regarding the addiction, the client is likely to proceed to the middle stages of the addiction.

As the alcoholism progresses to the middle stage, the alcoholic struggles to gain control over alcohol while working hard at keeping this struggle secret. Denial in the middle stage of the addiction is manifested by the alcoholic acknowledging the high alcohol consumption but insisting that this consumption is not abusive or problematic. At the end of the middle stage, the realities associated with constant drinking will erode the denial mechanism and force the alcoholic to admit to difficulties with alcohol.

As the late stage begins, the denial becomes focused on the need for treatment. The alcoholic may acknowledge the alcohol abuse but refuse to acknowledge the need for treatment. The addict may insist that the problem is not that bad and that treatment is unnecessary. If the alcoholic does agree to treatment, the denial may then become manifested as resistance to treatment. This form of denial usually surfaces when the addict needs to make decisions about the kind of treatment methods which are acceptable and how intensely the addict will engage in treatment.

EAP Intervention

Bell & Bell (1989) report that one of the most effective ways to combat workplace alcoholism is to establish an Employee Assistance Program (EAP) to provide an appropriate mechanism to both identify employees suffering from alcoholism and to refer these employees to treatment services. Tarrant (1989) cites that employers are dependant upon the physical and psychological health of their employees, and it is in the employer's best interest to assist the employee.

One study suggests that the employer's cost resultant from the alcoholic employee is difficult to calculate since it involes many kinds of costs, direct and indirect, including: absenteeism, increased use of health benefits, reduced productivity, lower employee morale, disciplinary or grievance proceedings, and related turnover costs (Anderson et al, 1989).

Quick (1989) asserts that the workplace is an ideal location to break through an alcoholic's denial. An employer can provide documented evidence that the individual's job performance is declining and provide motivation for the employee to seek assistance by making continued employment contingent upon successful alcohol intervention and a return to acceptable job performance. Cavanaugh (1990) cites that the attention of the alcoholic is more likely to be gained when an objective outsider, such as a supervisor, confronts the employee about

situations that are putting their jobs in jeopardy (Cavanaugh, 1990). The addict is motivated to at least initiate treatment in an effort to maintain employment.

Vodanovich & Reyna (1988) report that the EAP provides formal education to employees regarding the nature of alcoholism. The goals of the education program would be to reduce confusion and lack of specific knowledge about drugs. The education program that the EAP provides generally trains supervisors and management about potential symptoms of addiction while educating supervisors about enabling.

Interventions.

Weisberg & Hawes (1989) describe how in a typical intervention, related individuals try to get through the alcoholic's denial to persuade him or her to agree to enter an inpatient or appropriate outpatient program for alcoholism treatment. Gallant (1987) cites that an intervention with the alcoholic compresses the past crises caused by the misuse of alcohol into one dramatic confrontation in order to brush aside the denial mechanism and get the patient to agree to seek help.

Gallant (1987) stresses that professional assistance must always be a factor in the intervention to offer the alcoholic a choice of treatment modalities, each one leading to a more controlled treatment setting if the patient fails in the initial treatment. Professional

assistance is vital to the success of the intervention in that the family members must be treated if they are to remain firm with the alcoholic and cease enabling behaviors.

Kimball (1978) asserts that treating the family member is effective in that it is of primal importance that each family member gains an awareness of the harm that all concerned have suffered from the illness of addiction. Schaef (1987) cites that diseases of addiction and codependency are the same, and that they function in precisely the same way. Similarly, Gallant (1987) concludes that if the family members are enabling the addict, the therapist must point this out as gently as possible and request some changes in the enabler's behavior.

Working Through Denial.

Brissett (1988) concludes that denial seems the centerpiece, if not the driving force, in many forms of alcoholism treatment and rehabilitation. Dealing with an alcoholic's denial is therefor a, if not the, major component in many forms of rehabilitation. Kimball (1978) states that one vital point to be examined in looking at denial is to examine the nature of denial and those who contribute to this denial.

Amodeo & Liftik (1990) assert that clinicians need to view denial as a predictable phase in the treatment process that will ultimately strengthen the client's

recovery. Unless the alcoholic's denial has been successfully negotiated early in the treatment process, the treatment will be ineffective. In general, the helper should proceed slowly, build rapport, and supportively assist the alcoholic in understanding that you are there to help, not hurt. Schaef (1987) cites that the goal is to help the client admit to the alcoholism, for one cannot recover from an addiction unless one first admits that the addiction exists.

The Intake Assessment.

Amodeo & Liftik (1990) cite that the first step toward working through alcoholic denial begins at the intake or first session. The therapist should start the session by taking a drinking and drug history. The therapist needs to be specific and thorough without assuming that the client will easily volunteer information. Kimball (1978) stresses that the therapist should avoid assuming the "fixer" role in working with the client as it is important to avoid power struggles. Amodeo & Liftik (1990) assert that the goal is to identify difficulties in life areas by using the client's own feelings and thoughts.

Goff (1990) concludes that the point of the first interview is to determine where the individual is in the progression of the disease. Peele (1988) asserts that confrontation as well as acceptance, caring, and

honesty are therapeutic tools which play a role in facilitating the patients looking at the alcohol consumption in a different light. Metzger (1988) concludes that used correctly, techniques of attending, clarifying, paraphrasing, guiding, and summarizing can be potent tools in overcoming the alcoholic's resistance and in disarming defenses. Amodeo & Liftik (1990) stress that instead of discounting the client's views, the clinician should present an alternative interpretation of events and behaviors by reorganizing the problem to include repressed or rationalized issues.

The Alcoholic Diagnosis.

Amodeo & Liftik (1990) cite that the most common form of denial is rejection of the diagnosis. Gallant (1987) states that because it is extremely difficult to penetrate the alcoholic's denial, a diagnosis with complicated criteria can allow the client to further minimize the problem. Barnes, Aronson, & Delbanco (1987) conclude that to allow a client to avoid discussing the diagnosis of alcoholism only allows the patient to continue drinking and denying. By confronting the client with the diagnosis, the therapist does not allow the alcoholic to manipulate the treatment in a manner which supports the denial.

Westermeyer (1937) stresses that one must assiduously avoid any collusion with alcoholics in denying the

alcoholism or in projecting the problem elsewhere. Gallant (1987) states that if the client attempts to project the problem elsewhere, it is often effective to have the client respond to the varied questions with corroboration from family members or close friends. The involvement of family members or friends can be quite effective in decreasing the denial mechanism.

Inpatient Vs. Outpatient Treatment.

Barnes, Aronson, & Delbanco (1987) conclude that even if the client accepts the diagnosis of alcoholism, the therapist must realize that denial is usually still present and may resurface as an unwillingness to discuss in detail the problems resultant from the alcohol use. Gallant (1987) cites that outpatient treatment may be more acceptable to patients in the early stages of the addiction while the denial is still strong as the negative consequences are not that extreme.

Westermeyer (1937) cites that a critical prerequsite to successful treatment is abstinence. If a client is unable to remain abstinent while attending treatment, the treatment will be ineffective. Mueller & Ketcham (1987) conclude that abstinence is vital in breaking through denial because as the addiction becomes weakened through abstinence, the denial will subside. So, if a client insists on outpatient treatment, but is unable to remain abstinent long enough to complete the treatment,

inpatient treatment is indicated. The unsuccessful attempt at outpatient treatment may convince the alcoholic of the need for inpatient treatment.

Benefits of Group Treatment.

Gallant (1987) concludes that alcoholism intervention is generally performed on a group level after the initial therapeutic contacts. Gallant believes group treatment to be preferable in that the group may function to decrease the denial mechanism as the alcoholic continues with treatment. The goals of the group therapy are to penetrate the patient's denial mechanism and help the individual develop a healthy living experience within the group setting. Westermeyer (1937) asserts that the members of the group are likely to spot denial and confront the client; many patients accept confrontation better by group members rather than by clinicians. Gallant (1987) further asserts that although the alcoholic may use the denial expertly with staff, the alcoholic will have difficulty maintaining the denial in the presence of several other alcoholics. Group treatment should thus always accompany individual alcoholism intervention - on either a formal or informal level to work through denial.

CHAPTER 5

POST-TREATMENT DENIAL

Alcoholic Recovery

Mumey (1984) states that the disease of alcoholism can be conquered - not cured, but put in total remission. By denying that alcoholism is a lasting and irreversible condition, the alcoholic is inviting relapse. The anonymous authors of Alcoholics Anonymous (1976) stress that if an alcoholic is planning to stop drinking on a permanent basis, there must be no reservation of any kind, nor any lurking notion that someday he or she will be immune to alcohol as alcoholism continues to progress even if the alcoholic remains sober. Weisberg & Hawes (1989) state that progression is the clinical fact that an alcoholic seems to have an internal mechanism that drives the disease at a rate independent of external factors. Sobriety alone is not the solution, for the disease continues to progress with or without the consumption of alcohol.

Denial in Recovery

Kimball (1978) states that if an alcoholic is actively recovering, the battle with denial continues long into

recovery. Gorski & Miller (1986) stress that even if the alcoholic acknowledges the addiction and remains sober, the alcoholic is still accustomed to thinking in a way which supports the denial process. For, as denial intially developed on a subconscious level, seeds of continuing denial and symptoms of potential relapse develop subconsciously as well. The alcoholic may be genuinely unaware of recurring denial until it is too late and relapse occurs.

Gorski & Miller (1986) discuss that the denial experienced by the alcoholic in recovery is admittedly different from the denial experienced earlier in the addiction, before sobriety. The alcoholic now acknowledges the presence and the impact of the alcoholism, but the addict may believe that he or she can handle the addiction without continued help. The denial may be present in minor changes in thinking and behavior patterns which imply that the addiction is no longer a pressing concern for the alcoholic. Such denial and resultant behavioral changes are dangerous in that the alcoholic may revert to prior patterns of functioning: denial and eventual relapse.

Mueller & Ketcham (1987) assert that time, persistence, and a thorough understanding of denial are essential so that the walls of denial aren't quickly rebuilt. Once the alcoholic begins to "reuse" denial to cope with discomfort, the denial process begins to progress. Schaef

(1987) cites that for clients in different stages of recovery, even the smallest lie or dishonesty will push them back into their disease and threaten their sobriety.

Aftercare and AA

Kimball (1978) asserts that refusing to admit to the need for aftercare is another form of denial. Westermeyer (1937) states that the denial of the need for aftercare is dangerous as the anger, denial, and projection that mark the early stages of recovery will soon give way to grief and remorse. Alcoholics Anonymous (AA) is often a recommended addition to formal treatment as a form of aftercare.

Tournier (1979) discusses that since its founding in 1935, AA has come to dominate alcoholism as both ideology and as a treatment method. AA is a self-help program in which the alcoholic can learn about alcoholism from other alcoholics who exist in varying levels of recovery. Robertson (1988) cites that as the only requirement for attending an AA meeting is an honest desire to stop drinking, AA is open to all alcoholics who sincerely want to recover from their disease. Tournier (1979) reports that so successful have AA members been in proselytizing their ideas about alcohol dependence that their ideas have virtually been recognized and accepted as facts by most experts in the alcoholism field.

AA and Denial

Miller, Gorski, & Miller (1982) cite that acceptance of one's alcoholism is the first step of recovery. The anonymous authors of Alcoholics Anonymous (1976) emphasize that for alcoholics to recover, they must fully concede to their innermost selves that they are alcoholic and that this condition is irreversible. Through acceptance, alcoholics actively counter any remnants of denial. If one is to continuously affirm the fact that one is alcoholic, one is unable to deny the alcoholism. In the place of denial, Metzger (1988) cites that AA promomtes suppression of self-pity and other forms of negativity. The recovering alcoholic must fully accept the disease without using maladaptive denial or self-pity to cope with reality.

Mumey (1984) asserts that AA meetings are perhaps the best source of remembrance-sharing that an alcoholic can experience in recovery. The alcoholic is able to see first hand the denial experienced by other alcoholics. Parker (1988) states that a key element at any stage of recovery is recognition: seeing the need for change as fundamental to our best interests. By recognizing denial in other alcoholics, the recovering alcoholics are likely to recognize their own denial.

The 12 Step Program of AA

The anonymous authors of Hazeldon's book The 12

Steps of AA (1987) discuss how AA is based upon a 12 Step Program which functions to aid the alcoholic in the recovery process. The 12 Step Program of AA is important in that the program stipulates that the alcoholic must work on psychological recovery in addition to maintaining sobriety. One cannot deny that there is a psychological as well as a physical dependency upon alcohol. Through working the 12 Step Program, the recovering alcoholic must confront the psychological issues that undermine sobriety. This program is based upon the assumption that continued recovery from alcoholism is contingent upon the development of functional coping skills to be utilized in dealing with the psychological components of addiction.

Westermeyer (1937) discusses that the 12 Step Program helps the alcoholic build a new sense of identity. New identity may help the alcoholic to identify with other recovering persons and relinquish denial. Miller, Gorski, & Miller (1982) assert that one must openly accept the status of alcoholic to recover as progress in recovery cannot be made until denial is replaced by acceptance. Kurtz (1979) asserts that the self-centered alcoholic accepted as real only those issues which were subject to rationalizations and control. The alcoholic must now accept the reality of the disease. The alcoholic can thus openly admit to being alcoholic without experiencing undue guilt or shame.

The 12 Steps of AA (1987) assesses that several of the 12 Steps of AA are concerned with sublimating guilt and shame. Alcoholics were accustomed to living lives which were ruled by guilt which increases the need for denial. Kimball (1978) cites that the best expiation of guilt in the AA program may come from sharing with others and giving of oneself through service to others. Alcoholics Anonymous (1976) stresses that those alcoholics who are unable to recover are people who cannot or will not completely give themselves to the simple 12 Step Program, usually because they are incapable of being honest with themselves. The 12 Step Program is thus a lifelong program which requires alcoholics to be honest with themselves about their disease.

Alcoholics Anonymous (1976) describes how the 12 Step Program of AA was founded by Bill W. at the inception of AA. The twelve steps have remained unchanged since they were first introduced to alcoholics many decades ago. The 12 Steps to recovery are:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these

defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to all persons we had harmed, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 12 Step Program and Denial

The anonymous authors of Hazeldon's book Living Recovery (1990) discuss that an alcoholic who is recovering refers to an alcoholic who is living the principles of the 12 Step Program. A recovering alcoholic is winning the battle with alcohol on both a physical and psychological level. Physical sobriety is the first step of the battle; psychological "recovery" is the next necessary step in maintaining continued sobriety. A recovering alcoholic countermands denial by accepting the disease.

Step One requires the alcoholic to admit to being powerless over alcohol. Miller, Gorski, & Miller (1982) cite that an alcoholic who denies being powerless over alcohol has no hope of recovery. Living Recovery

(1990) discusses that a thorough understanding of our individual powerlessness must be solidly and firmly founded, or one will fail to arrest one's addiction.

Steps Two and Three are related to Step One. Alcoholics Anonymous (1976) emphasizes that these two steps ask the alcoholic to accept that a greater power exists and further requires the alcoholic to "make a decision" to turn one's will over to this higher power. This "higher power" is not necessarily God, but rather the alcoholic's perception of a greater power. Kurtz (1979) cites that AA asserts that the denial of the spiritual underlies all other denials which are characteristic of alcoholism. Alcoholics reportedly believe that they can control their alcoholism and their lives. Only through accepting that some things are beyond one's control can the alcoholic break through this cycle of denial and control. Miller, Gorski, & Miller (1982) cite that as the alcoholic works these first three steps of the program, the alcoholic progresses from denial to surrender.

Steps Four and Five attack the alcoholic's denial directly. Step Four requires alcoholics to make a searching and fearless moral inventory. Step Five requires alcoholics to admit to themselves, to God, and to another human being the exact nature of their wrongs. Miller, Gorski, & Miller (1982) discuss how through the process of creating a moral inventory and acknowledging one's wrongs, alcoholics

must be honest with themselves about themselves. The honesty involved in these two steps are vital in that honesty is necessary to interrupt any sobriety-based denial that may block the alcoholic's progress in recovery. Living Recovery (1990) cites that it is honesty with oneself and with others that breaks through denial. In this view, one must actively affirm one's addiction in an effort to counteract any denial regarding the addiction.

Steps Six and Seven require the alcoholic to ask the higher power to remove all shortcomings and defects of character. Steps Eight and Nine require the alcoholic to make a list of all persons harmed by the alcoholism and to be willing to make amends to these individuals, provided that this process does not impart further harm. Alcoholics Anonymous (1976) emphasizes how the alcoholic thus continues to affirm the negative effects of the addiction and "surrenders" to a higher power. Living Recovery (1990) states that real surrender includes a powerful desire for change, as well as a readiness to part with old ways.

Step Ten requires the recovering alcoholic to continue to take personal inventory and promptly be willing to admit to any wrongs. Alcoholics Anonymous (1976) stresses that the tenth step is different from the first nine steps in that the alcoholic is no longer looking at the past; the alcoholic is now concentrating on the present.

The goal is for the alcoholic to look for any signs of selfishness, dishonesty, resentment, or fear. The alcoholic is always on the lookout for recurring denial, as it occurs.

Step Eleven is essentially an expansion of the acceptance of a higher power. Alcoholics Anonymous (1976) discusses how the alcoholic strives to improve "contact" with the higher power, whatever his higher power might be. The alcoholic may engage in activities such as prayer or meditation to remain confident in this higher power. The overall goal of this step is for the alcoholic to become more disciplined in behavior. Through discipline, the alcoholic reportedly does not progress to prior levels of maladaptive functioning.

Step Twelve asks the alcoholic to "carry the message" reagarding recovery to other alcoholics. Living Recovery (1990) stresses that alcoholics are benefitted by this process as they recognize the need to continue to work on recovery by observing others and remembering life prior to recovery. Alcoholics Anonymous (1976) states that practical experience shows that nothing will so much insure immunity from drinking as intensive work with other alcoholics. Reportedly, work with other alcoholics works to keep the alcoholic sober when other activities fail. Indeed, it is perceived by AA that helping others is the foundation stone of the alcoholic's recovery.

The 12 Steps of AA (1987) discusses how the 12 Steps of AA constantly ask the alcoholic to affirm powerlessness over alcohol; the alcoholic also affirms the negative consequences of the disease. It is all too easy for a recovering alcoholic to regress to prior levels of functioning which invites relapse. The 12 Step Program of AA stresses that recovery is a lifelong process just as alcoholism is a lifelong disease.

CHAPTER 6

CONCUSION & RECOMMENDATIONS

Concluding Remarks

Denial is a key factor in the successful treatment of alcoholics. It is accepted throughout the alcoholism field that denial prevents an alcoholic from seeking help at a time when the alcoholism remains in the early stages. Rather, "help" is usually attained only when the alcoholic hits a "bottom" so low that the denial is broken. Throughout treatment, denial resurfaces and sabatoges the success of the treatment. Even after treatment, the alcoholic is almost expected to relapse as a result of sobriety-based denial.

Sadly, many alcoholics do seek treatment late in the disease. It is also likely that those who do seek intervention will eventually relapse. Although no statistics exist, it is assumed by professionals in the alcoholism field that those alcoholics who do not relapse are actively involved with AA and their 12 Step Program. It may be suggested that recovering alcoholics maintain sobriety as they work through the 12 Step Program and actively confront alcoholic denial.

It is no wonder then that the literature in the

alcoholism field is so pessimistic regarding the issue of denial. Denial does prevent treatment and continues to undermine treatment once treatment is initiated. Yet, the denial discussed in the literature describes denial as it exists late in the disease. Steps can be taken to work through denial while the alcoholic is in the early stages of the disease thereby ceasing the progression of the alcoholism.

Denial functions as a defense mechansim to protect the alcoholic from the pain of the addiction. Denial is also experienced by family members, friends, coworkers, employers, and even society itself. Denial can be perceived as an adaptive defense mechanism in that the denial protects the individual from confronting a reality that is painful. The perfect example would be the terminal cancer patient who denies that he is dying. The acceptance of the inevitable outcome of death is only experienced when the patient is strong enough to accept that he or she is dying. The denial as experienced by alcoholics can be adaptive as the denial protects the alcoholic from the pain initially. Yet, this denial blinds the alcoholic to the addiction so the addiction is untreated and continues to progress. Ironically, the very defense mechanism that initially protects the addict hurts the addict by allowing the disease to become even more painful.

Denial prior to treatment causes the alcoholic and the family to exist in a sick, addicted environment.

Yet, the progression of denial can be halted through education about addiction and denial. Education is important in ceasing the progression of denial in that much denial takes the form of prejudice, ignorance, and misinformation regarding alcoholism. When individuals are armed with factual knowledge about alcoholism, denial loses its power as the alcoholic and the family understand the disease of alcoholism. Such early intervention may succeed by preventing the development of the addiction or by at least ceasing the progression of the addiction.

Denial may still exist after appropriate education, but the alcoholic and his family now recognize the danger and the interpersonal effects of alcohol abuse. Such recognition regarding the progression of alcoholism should prevent the further progression of denial. Alcoholics are likely to reach out for assistance sooner, before their lives fall apart and they hit "bottom". If the alcoholic is already in the late stage of the addiction, appropriate education only reinforces the need for intervention. For those addicts who continue to deny, despite education, educated family members are likely to reach out for help themselves.

The informed family member or codependent is likely to respond to education by seeking alcoholism intervention. The therapist can then aid the client in taking steps to cease any enabling behavior and stand firm in not tolerating the behavior of the addict. This approach

will definitely aid the codependent in learning appropriate coping skills and should also be effective in bringing the alcoholic in for treatment. Codependents who have been treated for their "disease" can aid the alcoholic in achieving and maintaining sobriety.

In the same vein, informed employers can protect their businesses from the costly impact of workplace substance abuse. Alcoholics need their jobs to support their addiction. Generally, by the time problems related to alcoholism occur within the workplace, the alcoholic is in the middle to late stages of the disease. Documentation, supportive confrontation regarding declining job performance, and a well established policy regarding alcohol or drug abuse should have an effect in breaking through the addict's denial. The addict may be able to project blame for problems experienced personally, but an EAP should be able to curtail the employee's ability to project blame for workplace issues. Once the alcoholic is aware of problems resultant from the drinking, the denial begins to weaken. An effective EAP can also serve to prevent the occurence of workplace substance abuse through education and related company disciplinary procedures.

Once the alcoholic reaches out for treatment, the therapist can help the client break through denial by concentrating on the facts of the addiction. Once the alcoholic fully acknowledges the end result of the

addiction, the client is likely to cease denying the maladaptive power of the alcohol consumption. Even in recovery, the alcoholic must continue to focus on the negative effects of the disease in an endless effort to counter any recurring denial and prevent relapse. Educated family members, coworkers, and friends can aid the addict throughout recovery by allowing the addict to own up to his addiction and its negative effects without denial.

Denial does persist into recovery. The 12 Step Program of AA confronts denial in recovery by constantly affirming the prescence of the disease and by acknowledging the negative effects of the drinking. As a result of recurrring denial, it is fairly common for the recovering alcoholic to spend the first few years of recovery working and reworking the first five steps of the 12 Step Program. Even if the denial returns and recovery begins to weaken, the alcoholic has the fellowship of alcoholics to assist him or her by confronting this denial directly. As such, membership in AA appears to be a necessary component to the alcoholic's continued recovery.

Recommendations for Further Research

Further research would be beneficial regarding denial as it exists after treatment is concluded. Research conducted in the area of relapse prevention concludes that relapse often occurs when the recovering alcoholic

experiences recurring denial. Relapse thus becomes the expected response to denial in recovery.

It is generally accepted that recovering alcoholics who are willing to work the 12 Step Program of AA work through recurring, maladaptive denial. Unfortunately, due to the anonymous nature of AA, there is no way to statistically verify the success of AA. We know that AA has a strong following and that many alcoholics who drop out of AA eventually relapse. What we do not know is the number of alcoholics who successfully recover from alcoholism without continued attendance at AA. As such, we can only conclude that AA works because of its apparent success.

With respect to alcoholics who drop out of AA, we most often are only familiar with those alcoholics who relapse and show back up in treatment programs. We have no way of referencing alcoholics who are successful in maintaining sobriety without AA. As such, we presume that if an alcoholic is in recovery then he must be involved with AA. It would be beneficial if treatment programs would track alcoholics after the conclusion of treatment. Only then could we determine whether alcoholics are successful in maintaining sobriety as a result of the 12 Step Program.

It is often assumed that clients who do not feel the need for AA are denying their disease and thus relapse prone. Further research would be beneficial in determining

if alcoholics who drop out of AA do so because of denial. It is quite possible that an alcoholic may deny the need for AA attendance yet fully accept the presence of the alcoholism. Further research in this area would provide statistical facts regarding the link between AA involvement and sobriety. In the same manner, further research would be beneficial in the area of alcoholic progression, after sobriety is attained. It is accepted that the alcoholism continues to progress - throughout sobriety. It would be beneficial if further studies were to identify the variables of progressive alcoholism without continued alcohol consumption.

Current research focuses on the benefit of employee assistance programs to employers from a dollars and cents viewpoint. In the same manner, current research focuses on how treatment for codependency helps the codependent. It is assumed that companies that do not tolerate workplace substance abuse are effective in decreasing denial just as it is assumed that treated codependent systems are effective in helping the alcoholic. Further reseach would be beneficial in determining the actual effects of education, employee assistance programs, and codependency treatment on the progression of alcoholic denial.

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